# THE ROLE OF LOCAL GOVERNMENT IN THE PROVISION OF HEALTH AND SOCIAL SERVICES IN CANADA

The Canadian Council on Social Development

Le Conseil canadien de Développement social

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# THE ROLE OF LOCAL GOVERNMENT IN THE PROVISION OF HEALTH AND SOCIAL SERVICES IN CANADA

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TABLE OF CONTENTS


| | Page |
|---|---|
| Preface | v |
| The Need for a Re-Examination | 1 |
| Re-Assessment in Other Countries | 3 |
| Historical Overview of the Role of Local Governments in Canada | 5 |
| Health Services | 5 |
| Social Services | 8 |
| Summary Overview | 11 |
| An Overview of Current Provincial Differences | 13 |
| Types of Health and Social Services Provided by Local Government | 19 |
| The Role of Local Government in Financing Health and Social Services | 27 |
| The Role of Local Government in Planning | 33 |
| The Role of Local Government in the Administration and Delivery of Health and Social Services | 35 |
| A Greater Role for Local Government: Prospects and Problems | 39 |
| Arguments For and Against a Greater Role for Local Governments | 41 |
| The Revenue Constraint | 44 |
| Administration | 47 |
| Planning | 48 |
| Delivery of Services | 49 |
| Concluding Comments | 51 |
| Bibliography | 55 |

## PREFACE

An initial version of this monograph was prepared for presentation and discussion in one of the workshops held as part of the national conference on "Improving the Delivery of Community-Based Health and Social Services" held in Ottawa in late November 1985, and sponsored by the Canadian Council on Social Development. The workshop was attended by about 65 persons, including academics, officials from municipal, provincial and federal governments, consumer organizations, practitioners from the health and social services fields, and representatives from a number of associations concerned with health and social policy reform and reorganization. This monograph has benefitted from the workshop discussion as well as several reviewers' comments and observations on the earlier draft, for which we thank all concerned.

The responsibilities of the various levels of government in the provision of health and social services have changed considerably over the past few decades. We argue that there is a legitimate need to re-examine the current role of local governments in these areas and to assess the problems with, and prospects of, altering their roles. In this re-examination, it is important to consider the general concepts of "role" or "responsibility" more specifically, that is, in terms of policy making, financing, planning, administration and the actual delivery of services.

The questions we raise are, no doubt, very complex. We found it difficult, and suggest that it is impossible, to come up with a tidy, well-defined and universal prescription for the proper role for local governments in these areas of social policy. The reasons lie in the tremendous diversity in the size, resources and political history and interests which characterize local governments in Canada. We can only hope, however, that our analysis and answers will stimulate the further analyses and discussion that the subject deserves.

## THE NEED FOR A RE-EXAMINATION

The evolution of the welfare state in Canada transformed the role of local governments in the provision of health and social services. Today, fiscal difficulties at all levels of government, uncertainty about long-term economic growth, frustration with the perceived and real shortcomings of redistributive policies, and the resurgence of conservative political currents, have led to a critical reassessment of the ideological and social policy underpinnings of the welfare state.

Some of the proposed changes to the nature and design of the policies and programs that collectively make up the welfare state could have a significant impact on many local governments in Canada. An example of such a policy change is the advocacy of guaranteed annual income policy in the recently-released Macdonald Commission Report (Royal Commission on the Economic Union and Development Prospects for Canada, Volume Two, Part V, 1985). While the notion of a guaranteed annual income has been around for well over two decades, it is now less radical and more widely acceptable as a public policy than it was previously. Such a policy would be achieved through a Universal Income Security Program (UISP) which would replace a number of federal tax and transfer schemes: the guaranteed income supplement for the aged, family allowance, child tax credits, child tax exemption, spousal tax exemption, federal contributions to social assistance, federal housing subsidies and possibly the personal tax exemption (Drover, 1985). Evidently, the UISP would replace some of the social assistance programs which involve local governments. The implications of such a policy for the role of local government is significant and thus must be carefully assessed for both current and future social policy planning at all levels of government.

It should be noted that, while a guaranteed annual income scheme would affect local governments directly, virtually any major change in social policy by federal or provincial governments would at least have important indirect effects. For example, recent plans by the federal government to reduce its transfer payments to the provinces may force provinces to reduce their transfer payments to local governments. The Federation of Canadian Municipalities foresees serious problems at the municipal level as a result of the federal government's proposed cutbacks and restraints in the Established Programs and Fiscal Equalization transfer programs (The Citizen, December 16, 1985).

The Macdonald Commission also recommended "the continuing devolution of responsibility for delivering social services to the community level and to non-profit associations" (Royal Commission..., 1985, Volume Two, p. 826). Implementing this recommendation too would have important implications for the role of local government in the provision of social services.

Proposed changes in health and social policy are, of course, not the only reason that the role of local government in health and social services must be reconsidered. A re-examination is also necessitated by the persistent advocacy of several structural and organizational reforms of the health and social services delivery systems. These reforms include the regionalization of health and social services, the integration of health and social services delivery systems to develop a holistic human services system, improvements in service delivery mechanisms such as those embodied in the concept of community health centres or Quebec's CLSCs, and the need to rationalize the hospital sector. The growing demand for home care services; concerns about the quantity and, perhaps more importantly, the quality of nursing home services; the crisis in social housing and day care services; the potential role for local government in health promotion and illness prevention; and the increasing recognition of the negative consequences of deinstitutionalization are among the many issues which compel a re-assessment of the roles and responsibilities of various levels of government. Such a re-assessment may also be warranted to make the major policy and administrative decision-makers in the health and social services sectors more accountable to the consumers, and to achieve greater and more meaningful consumer participation in the planning and decisions affecting health and social services.

With respect to the current efforts of conservative governments in Canada to reduce social welfare expenditures, it should be noted that their assumption of an overly-generous and bloated welfare state may be more mirage than reality. A 1984 survey by the Organization for Economic Co-operation and Development (OECD) revealed that Canada spends less on social security than five of the seven richest Western countries. For example, in 1982, Canada devoted 11.8 per cent of its gross domestic product to social services, compared with an average of 14.1 per cent by other rich industrialized nations, 28.3 per cent by the Netherlands and 18.8 per cent by Sweden (The Citizen, Dec. 19, 1985). The OECD report has never been countered by the federal government. Nevertheless, its attempts to reduce the size of social security system can be expected to continue.

## RE-ASSESSMENT IN OTHER COUNTRIES

The role of local government in the provision of health and social services is being re-assessed in virtually all of the western industrialized countries. Comparatively speaking, there is in fact a greater urgency and poignancy to such a re-examination in other countries than in Canada. European local governments have traditionally had a greater role in the provision of health and social services than Canadian local governments.

The historical development of the role of cities and local governments in health and social services varies from one nation to another. In continental Europe, where cities were precursors to nation-states, they have historically enjoyed a greater degree of political autonomy and authority than British, and certainly, American and Canadian local governments. Regionalization of health and social services, of decision-making power, and of responsibility for delivering services, was part of the economic and social policy planning of a number of European countries for the past two to three decades (Tsalikis, 1985, p. 21).

In the U.K., local governments have been under severe fiscal and administrative pressure from the Thatcher government. There has been acute confrontation between local governments, -- particularly between labour-controlled municipal governments, such as Liverpool and London, which have sought to maintain social services in the face of budget deficits, -- and the Conservative government, which has been determined to force a reduction in local public expenditures on such services by cutting back the transfer of funds to local governments. The Thatcher government's 1983 White Paper on "Streamlining the Cities, Government Proposals for Reorganizing Local Government in Greater London and the Metropolitan Counties" (Cmnd 9063) has been severely criticized by the left as an attack on "municipal socialism" (Blunkett and Green, 1983; Blackburn, 1984), and by academics of local government and the left as an attempt to remove "local democracy", generally defined as the right of local citizens to choose their own levels and forms of public services. Others interpret the attack on local government as nothing less than an attempt to erode the gains of the British welfare state (Cochrane, 1985).

In the United States, responsibility for the provision of health care for the poor has traditionally fallen upon local governments. Their present health expenditures alone account for between eight and nine per cent of the overall expenditures of local governments, a percentage that is much

higher than the roughly four to five per cent of expenditures of Canadian local governments. Expenditures on public health services, however, are much the same in both countries and the U.S. local governments' provision of personal health services to the poor accounts for their much greater allocation of local expenditures for health purposes. Our comprehensive, universal and national hospital and medical insurance programs obviate the need for such expenditures in Canada. The role of local government in financing, organizing and delivering health services has been subjected to considerable review and analysis in the United States (Jain, 1981; Davis and Millman, 1981). Much of the recent attention on the role of local government has been spurred by the difficulties and pressures local governments are experiencing in maintaining their level and range of services, let alone improving and extending their services to the growing numbers of urban poor and elderly.

The sources of U.S. local governments' fiscal predicament include the taxpayer revolt, which began in California and spread across the country; bouts of economic recession; inflation in the costs of health services two to three times the increase in the overall consumer price index; and, very importantly, the recent sharp reductions in federal aid to state and local government for health programs.

The cutback in federal funds is part of the so-called "New Federalism" initiative of President Reagan. It substantially re-defines the relationship among federal, state and local governments, significantly expanding the role of the state in the financing and governing of domestic programs. The New Federalism underscores the ideological differences between conservatives and liberals (at least in the United States). The conservatives are fearful of any expansion of the federal fiscal power and presence in social policy and the liberals are equally fearful of the capacities and inclinations of state governments.

The financial difficulties of many local governments have been sufficiently acute to force reductions in maternal and child health services, family planning, neighbourhood health services and many others, as amply illustrated in New York over the past 10 years (Tabb, 1982). Some states have responded by reducing the eligibility or the benefits for publicly-supported programs such as Medicaid and Medicare, thus forcing a greater number of the poor to seek care from local government or private charitable sources. Additional pressure on local government services is brought by early discharge from hospitals of many elderly patients as a consequence of Medicare's new method of reimbursing hospitals, through diagnostic-related groups or DRGs. Many are released into communities where nursing homes are full and home care inadequate. Patients are, in effect, "being sent to a no-care zone" (Wall Street Journal, June 25, 1985, p. 31).

It is apparent that, under fiscally-conservative governments in both Britain and the United States, the price exacted by the national and state (or regional) governments for continued aid to local governments in fiscal difficulties is retrenchment in the provision of social services (Tabb, 1982).

## HISTORICAL OVERVIEW OF THE ROLE OF LOCAL GOVERNMENTS IN CANADA

Local governments in Canada have neither a long history of involvement in health and social services, as in Europe, nor an extensive legal obligation to provide for the poor as do local governments in the U.S. It is difficult to do justice to the complicated history of the municipal role in a brief overview, especially when that history varied considerably from one province to the next. What are presented here are the broad trends that determined and characterized the role of local governments in Canada. Nevertheless, it is hoped that this broad description of the development of their roles will suffice and will illuminate and inform some of the issues that must be considered in assessing the present and future role of local governments.

In the earliest colonial period, provision for the poor, the sick and the unemployed fell almost entirely on benevolent institutions such as the churches. Even though local governments in many European countries had a considerable role and responsibility in the provision of health and social services to the destitute, when Upper Canada achieved colonial status in 1791, there was no legislation pertaining to these matters. Later, while the Poor Laws required communities to care for their own poor, few government services existed (beyond the local jail) and "welfare" often took the form of work programs in exchange for food.

The rapid influx of immigrants in the 19th century created new health and social problems which forced local governments to take actions to protect the well-being of their communities. Immigration brought rapid growth, urban congestion and poverty. Unemployment, especially during the three economic depressions of the late 19th century, overwhelmed charitable and voluntary organizations and compelled public relief measures. By 1874, 418 out of 515 municipalities were supporting relief recipients. Despite the Charity Act of 1874, which provided provincial subsidies to charities, no programs existed to assist the overburdened local governments which were providing for the poor out of local taxes.

### Health Services

Although social welfare programs were aimed at assisting individuals, local governments' original role in health was to protect the community as a whole. Indeed, it can be argued that an important reason for the present

differences in the provision of health and social services may be traced to this original municipal focus in the delivery of such services.

Epidemics of disease -- such as cholera in 1830, smallpox in 1869 and typhoid in 1874 -- almost wiped out some communities, especially in Lower Canada. When initial quarantine measures failed to arrest the spread of disease, communities initiated radical action, such as invoking local quarantines and preventing travel, in desperate attempts to protect themselves. Frequently unpopular and regarded as an infringement on individual freedoms, public health measures were often controversial (Bilson, 1984). Life in colonial Canada was often short and health was regarded as a result of individual behaviour rather than environmental factors. The fact that disease was most common and severe among the poor simply reinforced the view that their misfortune was due primarily to their own moral failings.

With successive epidemics, local and provincial boards of health were established in response to serious risks or threats that required collective action. Even then, they were originally intended only as temporary measures to deal with emergency situations, although gradually they became established on a more permanent basis. Local boards had, beyond the power of quarantine, the function of cleaning up the cities. Although many citizens refused to accept the idea that dirt and disease were related, Boards of Health directed by enlightened physicians hired men to get rid of garbage, inspected homes and livestock, ordered the cleansing of unacceptable premises and the closing of others, and effectively began the public health movement. Although they met with resistance and occasional violence, they eventually succeeded in establishing government's role and authority in matters of community health (Bilson, 1984).

Despite the activities and progress of local government as the main providers of public health services, and indeed a variety of social welfare services, the British North America Act recognized only two levels of government and gave the provinces jurisdiction over health, education and welfare services. The prevailing attitude was that such services ought to be kept to a minimum (Tsalikis, 1985).

Although they lacked the constitutional mandate, municipal governments continued to pursue a role in public health. For example, Ontario passed an act to provide for the continuous scrutiny of public health. Under this act, each municipal council become, in effect, a separate board of health and each council member a health officer. As councils were relatively indifferent to public health matters, the act was amended in 1884 to allow for the formation of a separate board of health appointed by council. The act also allowed municipalities to unite to form health districts for the purpose of providing services more efficiently. These local health boards became the vanguard of the vigorous public health movement of the early 20th century and created sanitation, immunization and inspection standards that would permanently change patterns of disease in Canada.

Conditions were especially dismal in cities, no doubt due to massive immigration and rapid urbanization. In Toronto in 1914, the Bureau of Municipal Research investigated housing conditions and revealed the appalling social, hygiene and economic conditions which had resulted from rapid unplanned urban growth (Rose, 1972). These findings and concerns were common to most municipalities. In the early part of this century, there were numerous efforts to provide health services, emergency relief and public works for the unemployed and the poor. Most of the services were provided primarily by local governments and voluntary organizations. The scope of local governments' activities again widened to include services they had not previously provided.

In the Prairie provinces, municipalities became involved in personal as well as public health services. In 1914, the municipality of Sarnia, Saskatchewan, offered an annual retainer to a physician who was about to leave. It is thus credited with founding the first government health insurance plan in Canada. So successful was this endeavour that, in 1916, the Rural Municipalities Act in Saskatchewan was amended to allow a tax levy by local governments to cover a Municipal Doctor scheme. At its peak, 107 municipalities, 14 towns and 59 villages had contracted for physician services. In 1917, the Union Hospital Act was expanded to enable local hospital boards to receive contributions from local governments, either on a fixed or per diem basis. Although there was no legislation allowing payment for patient care, except in the case of indigents, it seemed appropriate at the time to pay for all patients and collect tax revenues for this purpose. At least 10 municipalities in Alberta and Saskatchewan did so. Eventually, the legislation did change to accommodate the practice and, by 1942, 88 rural municipalities were operating municipal care plans (Royal Commission on Health Services, 1964).

These plans were quite successful in meeting the health needs of their local populations. However, many Canadians remained unprotected by municipal schemes. As well, many municipalities experienced difficulties in sustaining their health insurance schemes and other health and social services programs. These programs were later replaced by provincial insurance schemes. The Saskatchewan Hospitalization Act of 1946 established a premium schedule, payable to the municipalities, which covered 97 per cent of residents. Alberta established a Hospital Services Plan for basic services in 1949 on a 50/50 cost sharing basis with the municipalities; by 1953, Alberta added a second tier of optional special services for municipal governments. In 1957, with the enactment of the federal Hospital Insurance and Diagnostic Services Act, all of the provinces adopted, or were to adopt, a universal, comprehensive, publicly-funded hospital insurance scheme.

With the introduction of the federal Medical Care Act in 1968, again preceded by provincial insurance schemes covering necessary physician services, the municipal role in providing such personal health care services was further reduced. Thus, the national universal federal-provincial insurance schemes markedly reduced local government

responsibility for such services and concomitantly reduced the municipal share of total health expenditures. These schemes also marked, or at least hastened, a shift away from prevention through public health and toward medical service in hospitals or in doctors' offices.

**Social Services**

Until the 20th century, municipal governments were the major government providers of social welfare services. These services consisted of welfare or "relief" payments, provided only on a short-term and case-by-case basis. Services very much depended on the organization and generosity of the community in question. There were often no formal standards, either in terms of the level of assistance or the eligibility criteria. Commonly, citizens' boards considered each case on its individual merit (One Stop Service, 1984). The lack of formal government policy or programs was consistent with the onus on individuals and families to provide for themselves. Not surprisingly, there was a stigma attached to welfare recipients. Means and needs tests reflected this stigmatization by the local community. Welfare was only intended to provide temporary assistance for the most basic necessities and not for what was considered a reasonable standard of living.

During the early part of the century, a significant change occurred in the provision of social welfare services. A brief account of Ontario's development is fairly representative of the overall progression. Social welfare services had not really been a provincial or federal concern until the economic depression of 1913-1915 overwhelmed municipal resources. By 1920, the province and the municipalities started the Mothers Allowance program. Originally intended to supplement the part-time earnings of widows with dependent children, the costs were shared equally by municipal and provincial governments (Joint Steering Committee on Integration, Monitoring and Evaluation, 1984). This was a significant change because it created a province-wide program, provided long-term assistance and acknowledged the government's responsibility for the less fortunate. However, deciding which level of government was ultimately responsible for the program was to prove contentious for many years. Originally, applications were processed by municipal clerks, a local board and then sent to the province for processing. This lengthy procedure, which often took more than seven months, was eliminated when the province took over funding and administration of the program in 1937 (Joint Steering Committee on Integration, Monitoring and Evaluation, 1984).

Widespread unemployment and economic hardship in the industrial sector in the early 1920's created a need for relief far beyond the scope of municipalities. A somewhat unenthusiastic provincial government was forced into partnership with the municipalities, giving grants to provide winter works programs for two years. While the effects of these schemes were limited, they did set a precedent for cost-shared municipal-provincial programs.

During the Great Depression, the need became so widespread that provinces were hard pressed to provide sufficient funds and some municipalities went bankrupt. All three levels of government were forced to cooperate, however unwillingly, to provide assistance, although the resulting system of social welfare was generally inadequate. Unlike past depressions, the Great Depression created a massive need for assistance and few members of Canadian society were immune from its devastation. The federal government responded with the Appropriations Act, which offered $20 million for a relief fund but made it clear that the onus was still on the municipalities to support the unemployed. In 1935, the Government of Ontario proclaimed the Unemployment Relief Act which again placed the responsibility for relief squarely on the municipalities. The following years involved long and heated negotiations with the municipalities as they continued their efforts to secure federal and provincial assistance in meeting local social welfare obligations (AMO, 1985). By 1939, a cost-sharing agreement was reached which reduced the municipal contribution to 20 per cent of relief funds while the other two governments each contributed 40 per cent.

"In the absence of a well-defined framework for accommodation between the two levels of government (federal and provincial), progress in the creation of national social policy was tentative and slow. Provincial programs developed prior to the Second World War were usually ad hoc responses to emergency situations: in general, provincial governments lacked both the will and the resources to establish coherent social policies on a permanent basis" (Hum, 1983, p. 13). It was only during the post-war prosperity that intergovernmental relations improved. In response to growing public pressure, the provinces, with the assistance of the federal government, started the health and social programs which form the foundation of the present-day welfare state. Social service and welfare needs were reduced as unemployment levels dropped precipitously. The traditional municipal role eventually disappeared in most provinces. Ontario was one province where it did not.

The 1960s brought economic prosperity and massive expansion of social services. The new programs went beyond conventional social assistance to meet the needs of groups other than the poor. The elderly, disabled, children and other special needs groups benefitted from the surge of welfare programs. This expansion, paralleled in other industrial countries (Flora and Heidenheimer, 1981), was the result of public concern over rights, equity and human dignity. Governments at all levels responded in an attempt to redistribute opportunity, income and wealth more evenly in Canada, as evidenced by the federal Canada Assistance Plan, which consolidated a series of federal programs designed to meet specific social welfare needs (Hum, 1983). The plan is a cost-shared program in which the federal share is half of all incurred costs. CAP is supposed to provide a funding formula for a comprehensive social welfare system in accordance with provincial preferences. It has been described as "an extremely popular program" (Matheson, 1984) and was recently endorsed by the Breau Report (Parliamentary Task Force on Federal-Provincial Fiscal Arrangements, 1981).

Its principal advantage is its flexibility; it permits variation in the services provided by the provinces, an important feature in light of the jurisdictional authority of the provinces over social welfare matters. Its other main advantage is that CAP allows the financial risk of excessive and unanticipated social welfare expenditures to be shared. Its main shortcoming, at least for the federal government, is that the provinces and their local governments, as program designers and deliverers, collectively determine the amount of federal spending. As well, provincial discretion in programs supported by CAP has resulted in significant differences among the provinces in the levels and types of social services and assistance. Indeed, it can be argued that the level of services does not necessarily correspond to the level of need in the provinces (Hum, 1983). Instead, the level of services is determined by the province's fiscal capacity and, of course, by the government's political ideology. Finally, the overlapping administrations under the CAP increase program delivery cost and often result in strained relations between the levels of government.

While the CAP primarily involves the provincial and federal government, it is an important source of funds for many municipal social programs, such as the Preventive Social Service Program in Alberta or the general welfare programs in Ontario.

Local governments and voluntary agencies are the main providers of personal social services in Canada (Hepworth, 1975). Over the past two decades, local governments have also assumed responsibility for a number of categorical programs for high-risk groups or for those with special needs which could not be readily met through national or province-wide programs. Local government programs may provide education, counselling and vocational training programs for the physically or mentally handicapped. As well, they may offer a myriad of child care services, vocational rehabilitation and recreation programs for the aged, day care centres, home care, dental clinics for the poor, residential protection for battered women and equal-opportunity employment programs.

Another noteworthy development of the past two decades, especially in the recent period, is the development of an exchange network, though largely informal, which links local government with public health units, voluntary community-based health and social services organizations, hospitals and community health centres. Nevertheless, there is continuing need to improve co-ordination and cooperation between government and community-based service providers.

"It is generally felt that duplication of services, confusion of providers and recipients of services, regional disparities, and variably defined responsibility for social development, are chronic ills anywhere in Canada". (Tsalikis, 1985, p. 20)

**Summary Overview**

What is clear from this sketchy historical account is that the responsibility for health care and some social services was transferred away from municipal governments to provincial and federal governments. Frequent periods of economic recession and depression had barred municipalities from providing more services, despite growing needs. Demands for new services, and the need to improve existing ones, simply outgrew local authorities' fiscal capacity to provide an acceptable level of service (Rose, 1972). This is not to say that local governments no longer play a role in these services, but simply that they are no longer the primary players. Despite this decline, it must be noted that, somewhat paradoxically, local governments are now involved in a far wider range of health and social services than they were 50 or 60 years ago. This is, of course, also true of provincial and federal governments.

While few details of the actual provision of services by local governments were provided in this overview (that is, population coverage, kinds of service, levels of service, expenditures, etc.) it is important to note that wide discrepancies in services and eligibility criteria characterized local government programs in these areas. The reduction in the role of local government also brought about a concomitant reduction in the disparity in health and social services. This is not to suggest that the greater participation of provincial and federal governments brought about equality of service provision, but merely to suggest that it did bring about a greater degree of homogeneity across municipalities. Indeed, two trends -- centralization of financing from local to provincial and national governments, and the emergence of the concept of universality in social policy -- were parallel and interrelated. These trends are most evident in health and income security policies, of which federal cost-shared Hospital Insurance and Medicare programs have been mentioned.

It should be noted that the long and extensive federal role in the income security area has been fairly acceptable to the provinces. It started with the Appropriations Act of the 1920s which gave cost-shared relief payments to municipalities, and was followed by a variety of other initiatives including the Old Age Pensions Act of 1927, Blind Persons and Old Age Acts of 1951, the Disabled Persons Act of 1954, the Unemployment Assistance Act of 1956, and the Canada Assistance Plan of 1966.

The federal role in income security is massive. "In fact, CAP represents only 10 per cent of federal spending in the welfare field. Close to 90 per cent is carried out through Unemployment Insurance, Family Allowances, Old Age Security, Guaranteed Income Supplements, the Canada Pension Plan, Spouses Allowance and the Child Tax Credit" (Matheson, 1984, p. 38). Traditionally, municipal governments have had little input into, or responsibility for, income maintenance schemes except welfare programs.

However, the role of local government in the domain of personal and categorical social services has grown over the past four decades.

Especially noteworthy is the growth of the voluntary sector during this period and the support for this sector from all levels of government. The role of local governments and the voluntary sector in personal social services has been heightened and their roles in health and income security areas reduced. These shifting roles may or may not stem from a concrete plan for more comprehensive or better services to the public or, for that matter, for more efficient delivery of these services. There may not, indeed, be any factors that rationally explain these opposite trends in the role of local governments.

## AN OVERVIEW OF CURRENT PROVINCIAL DIFFERENCES

There are tremendous interprovincial differences in municipal governments' roles in the provision of health and social services. These differences have a long and complicated history. As well, they are far from static, as many provinces are reconsidering the role of local governments in these social policy areas. We present here a very brief overview of the present role of municipal governments in each province.

### Newfoundland, Prince Edward Island, New Brunswick

In Newfoundland, Prince Edward Island and New Brunswick, health and social services provision are strictly a provincial responsibility. In Newfoundland, municipalities make no contribution to health or hospital services nor do they assume any responsibilities for public assistance. Similarly, in New Brunswick, local governments have been excluded from health and social service provision since 1967, although there is some suggestion that current proposals for decentralizing responsibility for services to the regional level may include municipal governments. In P.E.I., the population is so small that municipal governments do little except enforce bylaws. The provincial government even levies and collects property taxes.

### Quebec

Since the first major reorganization of health and social services in Quebec in 1972, the provincial government has devolved considerable authority to the regional level. The establishment of local community health centres (CLSCs), which offer a degree of integrated health and social services, have been a provincial responsibility only minimally involving local governments. There does seem to be some interest, however, in increasing future involvement of local government, in order to make regional bodies more efficient and effective (Gazette, Oct. 19, 1985, A5).

### Nova Scotia

Historically, municipal governments have been involved in both health and social services far more in Nova Scotia than in other provinces. During the past 20 years, these roles have gradually decreased in response to

reports of Royal Commissions and other studies which recognized that the structure and taxation capabilities of local governments were unsuitable and had created deficiencies in many localities. For instance, a 1974 Royal Commission recommended reform of provincial-municipal responsibilities for the following reasons:

> At present, although the responsibility in Nova Scotia for education, health, social services and the administration of justice is divided between the provincial and municipal governments, the municipalities are to a very large degree making mandatory financial contributions for mandatory programs prescribed by the provincial government. Yet in most municipal units the municipal financial contribution to these four general services is larger than the total municipal expenditure on all local services. In consequence municipalities find that they can exercise very little effective control over the general services to which they contribute most of their revenues and that they do not have sufficient remaining funds to provide an adequate level of local services. (Royal Commission on Education, Public Services and Provincial-Municipal Relations, 1974)

Although the recommendations of the 1974 report were not implemented, municipal-provincial responsibilities were modified following a 1978 White Paper entitled "New Directions in Municipal Government in Nova Scotia". Under the Provincial Social Assistance Act, municipal governments are now authorized to provide financial assistance to those with short-term need on a cost-shared basis, under which they pay a maximum 25 per cent of the costs. A needs test is used to determine eligibility and payments are calculated on the basis of costs of food, clothing, shelter and so on. Each municipality is free to establish its own rates and may also grant emergency funds subject to provincial approval. The municipality is required to submit a yearly policy on social assistance which must conform to minimum provincial standards. Municipalities also pay one-third of maintenance costs for residents in homes for special care who require assistance and have been admitted to a facility. Municipalities may and do own and operate homes for special care and adult residential centres. They also pay for the maintenance of people in private facilities. Homemaker services are delivered mainly through municipal social service departments, with a maximum 25 per cent of the costs contributed by the municipalities.

Unlike most other provinces, public health services in Nova Scotia are almost exclusively a concern of the provincial government, which takes care of the delivery, planning, financing and administration of these services. Local government involvement is limited by legislation to participation in local boards of health. The boards' role is restricted to dealing with land use issues and mediation of complaints from local citizens about health issues; they have no direct impact on program delivery.

## Ontario

The municipal role in social services is an important one in Ontario. In 1981, more than 70,000 cases were assisted under the General Welfare Assistance Act (Joint Steering Committee on Integration, Monitoring and Evaluation, 1984). The program offers short-term or emergency assistance, subsidized about 80 per cent by the province and delivered by Indian bands as well as municipalities. Long-term assistance is provided by the province. The dual delivery system is confusing and time-consuming because recipients must apply twice, deal with two bureaucracies and be transferred from one system to another when short-term benefits expire and the need for assistance continues. Although not confined to Ontario, this problem has existed for almost 25 years. A recent pilot project transferring responsibility for both programs to the municipal level was favourably evaluated both by the participating municipalities and the provincial government. It has not been adopted province-wide partly due to the recent change in provincial governments in Ontario. Although the new Liberal government is willing to pursue integration of the income delivery systems, the municipalities have not collectively endorsed the concept because of their uncertainty and perhaps even suspicion concerning the fiscal and administrative role they will be expected to assume (AMO Report 85-2, 1985).

Municipalities also contribute 20 per cent of costs to children's services (Children's Aid Societies) and receive provincial subsidy for day care and related services operated by municipalities (Hurl, 1984), although subsidies for operating costs are being phased out.

Public health services are an important concern of Ontario local governments, as they fund 25 per cent of the operating costs of health units, except Metro Toronto which funds 60 per cent (Provincial and Municipal Finance: 1983). Traditionally, health units have been operated by autonomous boards of health although, at the time of writing, four health units are reporting directly to regional councils. Municipalities may own ambulance services although these are funded by the province. Municipal governments are important operators of homes for the aged through the extended care program. They also have the option of operating numerous health and social services for the elderly under cost-sharing formulas with provincial governments. In addition, many municipalities choose to support programs entirely from the local tax base (The Waterloo Region Social Resources Council: 1984). Some municipalities own hospitals or have representation on local hospital boards although all hospital care is funded by the Ontario Health Insurance Plan. Psychiatric care has traditionally been a provincial responsibility but some municipalities now provide community-based psychiatric programs, usually through the public health unit.

**Manitoba**

In Manitoba, municipalities provide a municipal assistance plan for those who do not qualify for the Provincial Social Allowance Program. The municipalities are reimbursed for the greater of either 80 per cent of the gross assistance payments, less $1 million, or 49 per cent of the gross assistance payments. The regional government of Winnipeg operates its own community health services but, in general, most services available are provincially-run.

**Saskatchewan**

Saskatchewan has a provincial social assistance program but two municipalities, Moose Jaw and Prince Albert, administer the Saskatchewan Assistance Plan. The program is financed by federal (CAP), provincial (Saskatchewan Assistance Plan) and municipal funds, as are the provincial-municipal welfare advisory and appeals boards. The two main cities, Regina and Saskatoon, have autonomous health departments for which they receive a per capita grant from the province ($2.50 per capita in 1981). In other municipalities, provincially-administered public health programs receive about 5 per cent of funding from the municipality. Municipalities which are members of road ambulance districts receive financial assistance from the province to either operate their own ambulance services or contract privately for them (Provincial and Municipal Finance: 1983).

**Alberta**

In Alberta, the cities of Calgary, Edmonton and 25 other local governments provide public health services (Provincial and Municipal Finance: 1983). Although the province has, in general, retained responsibility for health, these local boards also administer the provincially-funded home care program. Municipalities are required to provide land for hospital construction. The city of Edmonton continues to operate the province's only municipal hospital and is responsible for its deficit.

The provincial social assistance plan reimburses 90 per cent of the costs to the municipalities which choose to administer it. The province sets fairly rigid standards for service and must approve welfare worker appointments. The Alberta government encourages employable welfare assistance recipients to seek employment by providing them with education counselling skills, training and expanded day care facilities. Municipalities which choose to operate integrated day care are reimbursed 100 per cent for operating costs and some capital costs. Municipalities may also enter into an agreement with the province to provide family and community support services. This program provides a wide variety of services to improve social conditions in the community. Each program is locally autonomous and therefore offers unique services. Costs are shared 20 per cent by the municipalities and 80 per cent by the province. This program

typically offers services such as counselling, family life, parenting and child development programs, community information and referral services, volunteer co-ordination, homemakers, home help, meals-on-wheels, friendly visitors, senior citizen social programs, and youth and children programs. Homes for the aged are built by the province, but operating costs are met by municipal funds and by rent from the residents.

**British Columbia**

There are great variations in the local government role in public and personal health care services in B.C. The province provides services for about 61 per cent of the population under local boards for which the municipalities appoint the staff. Municipal governments contribute only about one per cent of the cost, due to a historic levy. The five metropolitan regions Vancouver, Richmond, Burnaby, North and West Vancouver, and New Westminster operate autonomous health departments with local revenue and provincial grants. In the Capital Region District, the province pays 70 per cent of the costs. There are plans under consideration to standardize services in the Vancouver area municipalities and to increase provincial funding in order to provide more uniform services across the province. Municipalities share with the province costs of the income assistance, day care, homemaker, child maintenance and health care programs (Provincial and Municipal Finance: 1981).

**Northwest Territories and the Yukon**

Originally developed as colonial appendages of southern Canada, the Northwest Territories (NWT) and Yukon are currently undergoing rapid constitutional and political changes at both the central and local government levels. These changes may have major effects on health and social services in the Territories. The central government of the NWT is unique in that it is a consensus government, although the Yukon Territorial Assembly is similar to southern provincial legislatures.

In the past, the federal government has been the sole provider of most services, although territorial governments have been gradually delegated increasing responsibility for education, social development, tourism and municipal affairs. The current moves towards self-government may eventually place much of the responsibility for health and social services at a local level if the recommendations of the Drury Report (1979) and other interest and lobby groups are followed.

The Drury Report concludes that community councils should be responsible for "soft" services, especially education, social services, housing, and land and resource management. Existing municipal structures are considered unsatisfactory because local governments' decision-making is concentrated on "hard" services while social, cultural and other "soft" services remain the responsibility of the central governments. This

dichotomy exists despite the unique needs of Inuit, Metis, Indian, and white residents of the territories.

Although attempts to establish local government began in the early century, it was not until the 1970s that both the NWT and Yukon had established comprehensive municipal ordinances and local government hierarchies. However, these municipal governments, originally intended to duplicate the form seen in southern Canada, have largely failed to develop as planned. The lack of a tax base in most communities, many with a population less than 1000, in combination with climatic, geographic and transportation problems, makes it difficult to fund or deliver traditional municipal services. In addition to being widely scattered, many communities are ethnically very diverse, making communication and co-operation among residents difficult. In addition, various associations of indigenous peoples, the Indian band system, and local advisory bodies such as those advising the Medical Services Branch of Health and Welfare Canada, frequently parallel or rival local governments. Recent changes to municipal structure in Yukon, and proposed for the NWT, have concentrated on adapting the southern form of government to northern needs and on broadening municipal functions to include soft services (Weller 1983). Municipal governments are now minimally involved in these areas, although the town of Frobisher Bay does administer the NWT social services programs. Diverse programs are required to suit the widely varying social, cultural and health needs of communities. Accommodating these needs means that, in the foreseeable future, municipalities may also assume far more fiscal control and responsibility, particularly in the areas of public and environmental health, and of social welfare programs.

## TYPES OF HEALTH AND SOCIAL SERVICES PROVIDED BY LOCAL GOVERNMENT

There is a tremendous variation in the services and programs offered by municipal governments in Canada, not only between provinces but also within each province. To a large degree, this variation reflects differences in local need and priorities but it also results from individual local government structure, maturity, size and provincial policy. Many local governments, especially smaller ones, are involved only minimally, or not at all, in health care and social services and concentrate on traditional municipal services. However, many basic municipal services promote health and social well-being although they are not classified as health and social services -- a fact often overlooked. For example, the services which provide us with clean water, waste disposal, and other environmental and public health measures, prevent diseases that once plagued Canada.

Increasing urbanization and industrial location places a heavy burden on the environment. The growth in automobile use and industrial pollution is of concern to all levels of government. Toxic and other waste disposal in city sewers may fall under municipal jurisdiction, but few local governments are capable of monitoring and policing industrial waste disposal. Water and sewage treatment is a municipal responsibility in all provinces although provincial funding is available for capital projects. Recreation facilities, usually municipally-run, promote healthy lifestyles and encourage social interaction. Many unique and innovative health care and social services exist in municipalities; however, the following is intended as a general overview of common municipal roles and programs and not as a comprehensive list of services.

Although municipalities were once important providers of health care services in Canada, their role today is quite limited. With the advent of national health insurance, the provinces have steadily increased their involvement in health care. Following World War II, the rapid discovery and diffusion of medical technology and increased demand for services, together with rising service costs, simply outgrew the capacity of local governments to provide the services demanded by the public. This was especially true of hospital care. Municipal hospitals were once a common feature in the health care system in some provinces. The few which remain are funded by the provinces, although municipal governments may provide land for new construction, funds for capital expenditures and, in a few cases, may be responsible for operating deficits. In many communities, elected local officials serve on hospital boards and on district or regional health boards. They may be involved in community health centres

and may operate or indirectly support private ambulance services, although these services are actually funded by the provinces. The dominant provincial role in providing hospital-based health services excludes an important municipal role in all provinces.

Public health departments were traditionally a local responsibility and, although many provinces have taken over services, autonomous local health units still exist and local governments contribute to public health services in most provinces. Although the structure varies, generally a local board of health, including some elected officials, is responsible for public health in the area.

Many programs are commonly offered by public health units, including health education, maternal-child health, dental care, control of communicable diseases, inspection of food, water and buildings, and nutrition services. Many health units administer home care services for the elderly or convalescing patients although the provinces usually fund these services.

Dental services is an area where a few municipalities are expanding their role. Originally, preventive dental education and screening for school children were the only programs offered. While they remain the primary focus, many units are treating patients as well. Dental treatment is provided either through public health staff dentists or through a purchasing arrangement with private practitioners. These treatment programs are usually available either to children or to low-income families, especially families receiving social assistance.

Municipalities in many provinces play an important role in providing services to the elderly. They own and operate homes for the aged and nursing homes. In many provinces, municipalities are responsible for maintenance of persons in homes for the aged who cannot afford the fees. Services for the elderly are an area where local governments are expanding their role and initiating new programs. Many municipalities administer meals-on-wheels or give grants to voluntary organizations offering these services. They may also operate telephone safety checks, friendly visiting, library lending services to persons at home, homemakers, home help and a variety of other support programs. Recreation departments usually operate a variety of social, cultural and recreational programs aimed at the elderly or the handicapped. Many cities have a transit service for handicapped or elderly persons which is often supported by municipal funds. Municipalities are increasingly involved in the provision of housing for people with special needs, although funds for these initiatives usually come from federal or provincial sources.

Many municipalities in Canada have become interested in programs and policies to promote health. They have passed bylaws limiting or prohibiting smoking in a variety of public places. Some have taken a keen interest in drug abuse programs. Many provide facilities and programs for physical fitness. A few, such as Thunder Bay, have developed an alcohol

management policy in their recreation facilities (Thomson et al, 1984).

Municipal social service departments frequently administer and fund a portion of income assistance or welfare programs. In some provinces, local governments are required to provide a separate municipal welfare program to meet short-term needs of able-bodied, employable people. The federal government pays 50 per cent of the costs of these programs through the Canada Assistance Plan. The municipalities' share of costs varies tremendously among provinces and is determined by the existing provincial municipal agreement (Provincial and Municipal Finance: 1983).

In addition to the basic income assistance program, municipalities may offer supplemental aid programs for the needy. Depending on the agreement with the province, they may provide and partly fund rent supplement programs. They may also provide financial assistance to purchase dental and medical care and devices such as dentures, glasses, and other prostheses. As well, in a few cases, they may pay welfare recipients' moving or transportation expenses.

Municipalities in many provinces offer a variety of employment assistance programs, including assistance with job search skills, employment support services, education, municipal work programs for welfare recipients and sheltered workshops for the disabled. Many employment programs include day care subsidization for eligible participants with dependent children.

"Municipalities are becoming increasingly involved in local initiatives (local employment initiative or community economic development) that were first dominated by the federal, and later joined by provincial governments" (Ross, 1985, p. 37). In several larger municipalities there are "equal opportunity" employment programs to increase hiring of discriminated or underprivileged groups. Widespread unemployment and economic recession have also led to increased municipal activities to attract industry and business and, hence, promote better employment and economic growth opportunities (CCSD: 1985).

A number of local governments have established advisory committees on visible minorities to promote greater understanding among different ethnic groups and society generally, and to minimize or reduce prejudice and discrimination. Local governments can and are expected to play a role in fulfilling the goal of multiculturism espoused at all levels of government. In Canada's cities, the ethnic composition is changing rapidly and the inescapable tensions of multi-racial societies are often manifested in ways requiring governmental response.

Services for children, in particular day care services, are an important area of municipal concern in all provinces. Municipalities own and operate numerous day care centres and subsidize private home care programs. Private home programs are usually either affiliated with a day care centre or with a separate municipal agency which supervises child care

arrangements. Although municipal day care centres usually have some subsidized spaces available, most home care programs provide all care on a subsidized basis. Municipal governments are increasingly subsidizing more day care spaces and they often purchase space for their residents from private providers. Some local governments also provide grants to private centres. For example, Toronto City Council has committed $1 million a year to subsidizing salaries in non-profit day care centres and has increased by 1,000 the number of subsidized spaces available in 1985 (Globe and Mail, October 3, 1985).

Municipalities provide a variety of play, nursery school, swimming and other recreational programs for children as well as parenting programs. Although municipalities do not deliver services to needy children, they usually contribute to their costs and serve on child social agency boards. As well, many municipalities provide annual grants to voluntary agencies providing services to children.

The feminist movement has made the public more aware of women's unique needs, leading to the recent proliferation of community-based services designed specifically for women and supported by all levels of government as well as by private, voluntary and charitable groups. While many municipal governments are becoming increasingly involved in women's services, the commitment tends to be most evident in large cities. In general, there are few support services for women in rural areas. In 1985, the Canadian Advisory Council on the Status of Women estimated that 45 per cent of the Canadian population had no access to services such as transition houses for battered women. According to a 1981 survey, transition houses in Canada received twice as many requests for shelter as they could accommodate.

Transition houses and sexual assault centres are frequently funded in part by municipalities. Financial support may be provided through a direct grant or through room and board purchase agreements on a per diem basis with the facility. In addition, municipalities which operate social service programs frequently provide welfare services to victims. They do not usually provide capital funds, nor medical and legal expenses, nor employment or child care programs provided by these facilities. The facilities usually raise funds from private or voluntary sources for these needs.

Protection of assault victims falls to the municipal police force. In the past, the law and the courts have often failed to treat assaults of this nature as serious crimes nor have municipal police forces kept accurate records of domestic incidents. However, there is a trend towards requiring police to handle sexual assaults and wife battering more effectively (for example, by requiring police to automatically lay assault charges against batterers). Some large urban forces have updated training programs for officers and added special support teams. For example, the City of Toronto domestic response teams promote cooperation between Metro police and community social service agencies and are available to provide

immediate counselling and intervention in domestic disputes (AMO 83-13, 1983).

In addition, some municipalities support or operate drop-in centres, run womens' workshops and courses to meet special needs, or simply provide space for these activities. For example, the City of Ottawa's Women's Place/Place aux Femmes now offers a meeting place, workspace, mailing address and information service for women's groups. It may soon offer a library and counselling services and plans to organize workshops and discussion groups.

Although housing is often regarded as outside the traditional range of health and social services, it is an essential component of social and physical well-being. Because of the private market's failure to meet the needs of various groups, all governments have been involved in housing since the early part of the century. Although most responsibility for administration and delivery of programs has been delegated to the provincial and, in turn, municipal governments, the federal government has retained a strong role in the funding and regulation of housing programs, largely through the Canada Mortgage and Housing Corporation. The federal role recognizes the importance of housing to the national economy and the income redistributive effects of social housing programs. Government programs may be broadly categorized as either private market (home renewal, home ownership, private rental) or social housing programs (public housing, non-profit, rent supplements).

Most municipal governments are involved in housing. Their role in planning and regulating housing development in the community is well established. With the exception of small rural municipalities, housing activities (i.e. preparing the official plan, community planning, zoning and monitoring development) are considered key municipal functions. In addition, some municipalities, either by choice or necessity, play an important role in the provision of social housing in their communities.

The lack of affordable housing is an increasingly serious problem in many Canadian communities. Social housing programs are intended to accommodate people who, for whatever reason, cannot obtain suitable housing in the private market. In cities like Ottawa and Toronto, where vacancy rates have dipped below one per cent, rental accommodations are limited and, for special needs groups like the elderly or low-income families, the shortage is critical. Persistent high rates of unemployment have increased the demand for low-cost housing. The deinstitutionalization of psychiatric and other patients is another source of new demand. However, the conversion of older, low-rental housing to meet the demands of higher or middle income renters and homeowners has been a major factor in reducing the housing available for low-income groups. As areas of the community are revitalized by private developers, often with the assistance of government, housing is either removed from the rental market or is no longer affordable for its original tenants. Recent changes in federal government housing policy have seriously threatened the future of non-profit cooperative housing which has

become an increasingly important option for both low and middle class renters (CCSD Overview: 1985).

There has been a dramatic increase in the demand for emergency housing in the past five years. The growing numbers of homeless in both Canada and the U.S. have received the close scrutiny of media and governments. In January 1986, it was estimated that there were between 5,000 and 10,000 homeless people in Toronto and 30,000 to 40,000 in New York alone. Local governments, facing the reality of homelessness in their communities, have responded by establishing emergency shelters, soup kitchens and a limited number of social housing projects. For example, City Living in Ottawa purchased a rooming house to accommodate singles. Unfortunately, the number of new units available is only a small fraction of the community's requirements. Social assistance payments have simply not kept pace with the private rental market (CCSD, 1985, p. 3).

There is tremendous diversity in local government involvement in the housing market across the country. Despite recent cutbacks, municipalities can be involved in both federal and provincial social housing programs (Section 15.1, 15.6 of the National Housing Act 1938, 1944). While the programs vary, they generally participate in municipal non-profit or cooperative programs. For example, in Ontario, local governments may administer and fund 20 per cent of a mandatory rent supplement program associated with income assistance. They may also own or operate a wide variety of low-rental, rent-geared-to-income and special needs housing for the disabled and elderly. They are essentially free to select their involvement in social housing. At present, municipalities are not usually required to contribute funds to social housing, although the large regional municipalities often support local projects from their budgets. For example, Metro Toronto's 1984 budget allocated $20 million to provide housing for singles who did not qualify for other programs (AMO, 84-10, 1984).

Municipalities may encourage and support the efforts of private non-profit or cooperative groups which promote social housing through capital grants (usually levy reductions). They may also coordinate efforts of agencies within the community and act as a liaison or advocate to other levels of government on their behalf. Local government support of housing projects is an extremely important factor in their success because such projects require municipal zoning, licensing and service approval.

There is an inherent conflict in local governments' roles as community planners and social planners. It is obviously in their best interest to attract fully-employed residents who can pay high taxes and to discourage low-income families who will need community support from residing in their community. Local governments are frequently criticized for their lack of commitment to social housing. Their failure to provide more housing is to some degree attributable to the "not in my backyard" syndrome. While voters recognize the housing needs of the mentally retarded, ex-psychiatric

patients, the disabled, elderly and low-income families, they may not want to encourage them to live in their neighbourhoods. Attempts to integrate low and middle income families through rent supplement programs has met with some success. However, the problems with social and public housing projects do create barriers to a greater municipal commitment to them.

The widespread trend toward deinstitutionalizing psychiatric patients, ejecting them into communities ill-equipped to support them, is a well-documented problem. Their needs for shelter and support, training in life skills and access to medical care are not usually met in the lodging homes and boarding houses where they can afford to live. Renovation, stricter licensing and legislation have decreased the availability of even these houses. Split jurisdiction among ministries of health, social services and housing in most provinces means that appropriate programs and facilities have yet to be established in many communities. For example, Reverend Bill Jay claims that 95 per cent of the transients he sees at the Montreal City Mission are discharged mental patients (Gazette Oct. 19, 1985, A1 and A4). Yet another unforeseen and unfortunate effect of the de-institutionalization of psychiatric patients is that many end up in prisons where "they frequently mutilate themselves, are beaten and sexually abused by other prisoners" (Citizen, March 19, 1986, A17). Prisons can hardly be expected to rehabilitate "criminals" who are mentally ill. While some ex-patients may have been unnecessarily incarcerated in mental institutions before their deinstitutionalization, their incarceration in prisons is hardly a better option.

Care of the mentally ill has been almost exclusively a provincial function. However, there are a few municipal psychiatric hospitals in Canada and there is tremendous potential for expansion of the municipal role in community care of ex-psychiatric patients. A working committee on deinstitutionalization of the Associated Municipalities of Ontario is identifying major areas of municipal concern and addressing the role of municipalities in the provision of services (A.M.O. President's Report, August, 1985). Many municipalities, through their social service departments, have already established services for these people, such as drop-in centres or employment programs, and are attempting to establish standards and licensing procedures for boarding and lodging homes (AMO, 1980).

Housing for the elderly is an important municipal concern at present. The growing elderly population is no longer satisfied with limited institutional care. The desirability of independent or assisted community living, as well as institutional living options, have led to an unprecedented demand for housing programs for the elderly. Municipalities are important providers of care in residential programs like homes for the aged but may also provide assisted living housing, home support services and subsidized housing. For example, Cityhome in Toronto offers communal living for the elderly as an alternative to homes for the aged (AMO, 84-10, 1984). Again, however, the need and demand for appropriate housing is far beyond what is now available in the community.

Municipalities support a tremendous number of local voluntary or charitable groups which provide health and social services in the community. These groups include family counselling agencies, help referral services, social groups for the elderly and the like. Municipal support can take many forms, including direct funding, petitioning the provincial government on behalf of voluntary associations and agencies, or donating municipal facilities and services. The increase in voluntary community-based health and social services has admittedly made possible previously unavailable services, particularly in isolated communities. There is concern, however, that voluntarism allows government to renege on its commitment to welfare programs. Patrick Johnston, former president of the National Anti-Poverty Organization, warns that governments may see locally-based social and health care as a way to evade responsibility and reduce funding (Globe and Mail, November 27, 1985, A17).

## THE ROLE OF LOCAL GOVERNMENT IN FINANCING HEALTH AND SOCIAL SERVICES

Local governments' contributions to the financing of health care and social services are only a small percentage of their total costs to all levels of governments. In 1981 for instance, the provinces spent $13.12 billion on health and $9.61 billion on social services. The federal government spent an almost equal amount in both areas.

As can be seen in Table 1, local governments in Canada spent about $938 million on social services and $1.7 billion on health services in 1981. It is also evident that the year to year changes in spending vary markedly for both sets of services. These aggregate data, of course, mask very wide differences in provincial spending. There is no local government spending in P.E.I., N.B., and little in Quebec. However, in Saskatchewan and Alberta, local government spending on health services constitutes about 14 to 15 per cent of total local expenditure and, in Nova Scotia and Ontario, the proportion is around five per cent. In the case of social services, there is no local government spending in Newfoundland, P.E.I. and N.B., whereas in Nova Scotia such services account for almost 10 per cent of total local government expenditure. For Ontario the relevant figure is about six per cent. Local government expenditures for housing are negligible in all provinces except P.E.I., where local governments spend five per cent of their aggregate budgets on housing. In all other provinces, the analogous figure is less than one per cent and is virtually zero in N.S., Manitoba, Saskatchewan and B.C..

The amount contributed to health and social services by local governments depends mainly on provincial-municipal agreements. Some municipalities do fund some services entirely and provide grants and subsidies to local voluntary agencies without provincial assistance. For instance, the City of Ottawa funds 100 per cent of the costs of a dental program for low-income residents and emergency shelters and the city gives numerous grants to local service agencies. Generally speaking, however, local government contribution represents a set percentage of total service costs or a fixed dollar rate per capita, with the rest of the funds coming from the province. For example, in N.S., the municipal portion of program costs set by agreement between each municipality and the province is about 25 per cent of the total costs (Higgins, 1979).

**Table 1:** Local Government Expenditures on Specific Functions (All Provinces)

in thousands of dollars

| EXPENDITURES BY FUNCTION | HEALTH | SOCIAL SERVICES | HOUSING | TOTAL ON ALL FUNCTIONS |
|---|---|---|---|---|
| 1981 | 1,701,743 | 938,558 | 119,516 | 32,027,718 |
| % of total expenditures | 5.3 | 2.9 | 0.37 | 100.00 |
| 1982[p] | 1,567,941 | 1,122,318 | 113,940 | 35,888,969 |
| % of total expenditures | 4.3 | 3.1 | 0.32 | 100.00 |
| % of change 1981/82[p] | - 7.8 | + 19.5 | - 4.6 | + 12.0 |
| 1983[p] | 1,715,904 | 1,220,563 | 113,969 | 37,805,397 |
| % of total expenditures | 4.5 | 3.4 | 0.30 | 100.00 |
| % of change 1982[p] /83[p] | + 9.4 | + 17.66 | + 1.0 | + 5.3 |
| 1984[p] | 1,883,957 | 1,287,070 | 109,459 | 39,079,435 |
| % of total expenditures | 4.8 | 3.3 | 0.28 | 100.00 |
| % of change 1983[p] /84[p] | + 9.8 | - 2.5 | - 3.9 | + 3.3 |

[p] - preliminary statistics

Based on Statistics Canada figures (1985)

There are many programs -- public health and children's services -- to which some provinces require municipalities to contribute funds, but over which municipalities have no responsibility or fiscal control (AMO, 82-5, 82-13, 1982; Bird and Slack, 1983). Naturally, this arrangement has been a source of contention, especially since municipal governments are having difficulty in meeting their financial responsibilities and are reaching the limit of their traditional revenue sources (Bird and Slack, 1983).

Municipalities raise a large proportion of their money from property taxes and a small amount through licensing fees and fines. In addition, they receive provincial grants and funds for cost-shared programs. Manitoba gives the municipalities about 2.2 per cent of personal income tax revenue and one per cent of corporate taxes collected (Mirror, 1985).

Municipalities are entitled to borrow money either on the open market or from a specific fund to meet expenditures. Borrowing is, however, very tightly controlled, since the province would ultimately be responsible for debt (Plunkett, 1972). An independent quasi-judicial board or the provincial ministry in some provinces monitor borrowing and review budgets and capital expenditure proposals (Provincial and Municipal Finance: 1983). Municipalities are usually required to limit their long-term borrowing to a certain percentage of their taxable assessment. For example, Saskatchewan limits urban municipalities to borrowing 25 per cent of their taxable assessment for up to 40 years and rural municipalities to five per cent of their taxable assessment for up to 20 years (Provincial and Municipal Finance: 1981).

Although these tight controls limit the ability of local governments to seek new revenue sources, they have largely prevented the fiscal demise experienced by many local governments in the United States.

Provincial grants are becoming an increasing proportion of municipal revenue. Many are capital project grants to fund new buildings or to pay for services provided municipally and funded provincially (Provincial and Municipal Finance: 1981). Grants to municipalities vary in each province and are often very complex because they are administered by different provincial ministries. Most grants are conditional, meaning that they must be used for a specific purpose and must meet provincial standards. Conditional grants are not favoured by municipalities because they decrease municipalities' control over their services (Bird and Slack, 1983), but they are increasingly preferred by the provinces.

Many municipalities resent the increased provincial control of their financial affairs and have repeatedly asked for new tax sharing and unconditional grants schemes (AMO, 82-13, 1982) but without notable success. They have persistently complained about the endemic "fiscal imbalance": they are forced to rely on an inelastic source of tax revenue -- the property tax -- while service costs seem to rise faster than revenues. They are forced either to cut services or to turn to the provincial governments for funds.

An increasing portion of municipal expenditures are uncontrollable, meaning that they are not under the direct control of local councils. For example, in Ontario, municipalities must contribute 25 per cent of the costs of many public health programs as required by provincial legislation. The public health unit is accountable to the local Board of Health and the province. It is not accountable to council in all but a few regional areas. A great amount of uncontrollable costs can be attributed to health care and social service costs, particularly in provinces where municipalities provide mandatory programs. Ontario Bill 83 (The Act Respecting the Protection of the Health of the Public) has made a number of public health programs mandatory; municipalities must pay for these services but have little control over them due to a matching grant agreement with the provincial government. Service providers frequently complain that their ability to provide these programs is related less to local need than to the municipalities' budget constraints.

While there is disagreement about whether municipal government should be involved in the delivery of services, municipalities uniformly agree that it is unreasonable to require them to pay for services from limited funds when they have no control over expenditures (AMO, Report 82-13, 1982). For example, in many provinces municipalities pay a portion of the costs of children's services but are not involved in planning, administering or delivering programs. It is the provincial government that sets the standards of services which are then delivered by a private non-profit agency. Municipal officials may sit on the boards of children's services agencies but they cannot question whether the services are necessary, or determine the effectiveness or efficiency of the agencies' delivery systems (AMO, Report 21, 1980; Hurl, 1984).

The root problem, as the municipalities see it, is that they cannot be accountable to the local taxpayers under such a system. It is further argued that, when municipal contributions exceed their anticipated costs, local governments are forced to use funds designated for other activities. This predicament further undermines accountability to the taxpayers.

One of the traditional arguments against financing social and health services from property or local taxes, is that such services are public and have as their objective income redistribution that benefits society at large; thus, these services should be paid from national or provincial revenue. While there is evidence that the current municipal tax system limits local government's ability to meet demands for services, the issue of who pays is not a new one. The province and municipalities have wrangled over which one should be responsible for income assistance recipients since the Depression (Hepworth, 1975). Relations between municipal and provincial governments have traditionally been less than cordial. Most provinces have established a board or ministry to improve municipal-provincial relations. In general, because of their legislative and fiscal superiority, the provinces have been able to impose their systems of funding arrangements unilaterally and to increase costs to municipalities without their consent.

Municipal governments in some areas, particularly at the regional level, have more political influence and administrative competence than ever before (Feldman, 1981; Graham, 1981; Brownstone and Plunkett, 1983). Despite this expertise, funding arrangements between many municipal and provincial governments remain unsatisfactory. Provinces leave many local governments unable to perform their functions because of inadequate funds. This revenue constraint effectively limits any significant expansion of local governments' role in the provision of health and social services. While the municipally-funded portions of health and social services are relatively small, local governments do provide selective and targeted programs to groups whose needs might not otherwise be met. Local governments are, in that sense, a source of innovative and necessary programs.

## THE ROLE OF LOCAL GOVERNMENT IN PLANNING

The planning of health and social services is another area in which municipal governments do not have a large, direct or independent role. Although a few of the large regional municipalities can be regarded as important political forces, most municipal governments have little influence on provincial or federal policy and planning.

"Municipal authorities are usually regarded by federal and provincial politicians and officials less as partners in the governmental process than as yet another interest group, and often an undesirably troublesome one" (Bird and Slack, 1983, p. 116).

It is the provincial governments which do much of the planning. Although most local governments have a planning department or committee, its area of concern is zoning, bylaws and property services planning, not health or social services.

Municipal officials do represent local interests on planning bodies at the local, regional and provincial levels. For example, local officials usually sit on district or regional health councils, children's service boards, local health and hospital boards, and various housing authorities. They may also serve on social planning bodies, day care centre boards, nursing home boards and a variety of provincial-municipal committees. Admittedly, there is some independent planning of services at the local level, primarily by larger regional governments in the area of social services. However, the limited fiscal responsibility of local governments means that funding, and therefore planning, rest primarily with the province.

Municipal associations can and do influence provincial health and social policies through a variety of political processes. For example, Ontario municipalities have recently urged the province to drop plans to sell wine and beer in small independent grocery stores. Earlier, municipalities were among the advocates of revising the legal drinking age.

Thus, with a few exceptions, health and social service planning is an indirect municipal function. This in no way negates the importance of the municipal contributions to planning services. In fact, because of their expertise in zoning, building bylaws, and service and road access, their assistance is needed when sites for new facilities or services are being planned.

A good example of the planning capacity of local government can be found in Alberta, where local personal social service programs are planned, administered and delivered by a board of locally-elected officials under the provincial Preventive Social Services (P.S.S.) program. Under the program, which has been in place in some communities since the 1960s (Bella, 1980), a council of elected municipal officials plans and administers specific programs aimed at preventing social problems in the community. In 1980, Leslie Bella studied the success of P.S.S. in eight communities. Her report revealed that there was considerable variation in the perceived mandate and functions of the program but, in general, it was successful. The program is intended to allow municipal governments to plan and support programs aimed at preventing marriage and family breakdown, juvenile delinquency, problems for the elderly and handicapped and the like. The report revealed that most councils were able to assess local needs, and to plan and implement the needed programs (Bella, 1980).

It must also be acknowledged that regional governments are far more involved in planning than local governments. Many local agencies were originally conceived and supported by local councils although they may eventually operate independently. Many community referral services springing up across the country were initiated by local governments.

It is sometimes the case that local governments influence planning at the local level even when their official role is minimal. Even in communities where the elected government has no formal input to a planning body such as a district planning council, the power of informal communications and relations is important.

One of the reasons often cited for the lack of planning is that the municipal term of office is only two years, a period so short that it deters officials from investing time and effort in planning programs which take a long time to implement.

## THE ROLE OF LOCAL GOVERNMENT IN THE ADMINISTRATION AND DELIVERY OF HEALTH AND SOCIAL SERVICES

It is impossible to describe local governments' involvement in the delivery and administration of health and social service programs in general terms, because of tremendous variations due to local capacity, need and location.

Municipal governments, like other bureaucracies, administer services to a system of departments and committees. Administrative policy-making is the responsibility of the elected council but is implemented by municipal employees.

Local governments may fund services which employ municipal employees although they do not actually administer the programs. For example, local public health units can be administered by a local Board of Health although they receive municipal funds and employ municipal inspectors. Similarly, community health centres may operate with assistance from local government but are usually governed by a special board and funded primarily by the province, so they cannot be considered municipally-administered services.

In small communities, where municipal employees are few and the tax base limited, many social and health programs are operated by local private and voluntary bodies. Although the municipality does not administer services, it may have members on the board, give grants, or supply support services such as typing, photocopying, maintenance and utilities.

In other instances, local governments may deliver services which they do not administer. For example, local governments may build and maintain social housing projects which are administered by a separate board.

There is increasing recognition of the administrative competence of local governments, particularly at the regional level (One Stop Service, 1984). A number of provincial ministries have expressed interest in decentralizing administrative responsibilities to the local government level. For example, the Ontario Ministry of Community and Social Services wishes to increase the municipal role in both income assistance and children's services (AMO, 82-5, 1982).

Integrating health and social services is a popular, if largely unfulfilled idea in Canada (except for some success in Quebec). However, local governments have in some instances achieved a desirable level of

integration for some groups, such as the elderly. For example, in the Region of Ottawa-Carleton a number of services for the elderly -- including tele-check, friendly visiting and meals-on-wheels -- are operated in conjunction with the homes for the aged. Relief services for families caring for the elderly at home, care of the elderly in institutions and support services for the elderly in the community are integrated at the local level.

Local governments frequently choose not to deliver services themselves but to purchase services from private and public programs on behalf of their residents. For example, home care programs may be municipally-administered through local public health units or homes for the aged, but services delivery may be purchased from the Victoria Order of Nurses and a variety of other private providers.

In some cases, however, municipalities are expanding their delivery role because they can provide services more economically than can other sources. For example, many local health units offer dental treatment provided by public health dentists to needy residents. These services are less costly than purchasing care from private dentists. In Hamilton-Wentworth, the dental division reported in 1983 that the average cost per appointment for municipal service was $37, compared to $66 for the private practice market. It is important to recognize that this service was available to families receiving social assistance, pensions, compensation and unemployment benefits as well as to low-income wage-earning families (Annual Report of the Hamilton-Wentworth Regional Board of Health, 1983).

One of the advantages of municipally-based services is that they can either deliver the services themselves or purchase them, whichever is more efficient. Unlike higher levels of government, they are not bound to province-wide policies but can take advantage of local services. Because service standards are usually set provincially, wide discrepancies among municipalities and inferior services can be avoided, and local flexibility and accountability can be maintained. Recognition of the advantages of municipal administration must be balanced by an appreciation of the hazards it may pose. For example, fundamental environmental health measures, like water and sewage treatment, are well-established municipal responsibilities. This situation has arisen both as a matter of tradition and in recognition that the urban or regional government is best placed to manage a wide range of environmental measures.

Local governments have, in general, paid considerable attention to fulfilling these responsibilities; however, in many instances, the demands have exceeded their capacity, due to the complex nature of these hazards and to the high costs of dealing with them effectively. Local governments' failure to protect the community from environmental hazards is not limited to a single region: urban air, water and sewage pollution spill over from one area to another. Public and media attention on global industrial pollution may well be somewhat misdirected, as urban pollution may prove to be more dangerous to our health. Concern about local governments' capacity

to effectively manage the environment is not new. A 1971 federal government study addressing this problem stated that both provincial and federal government intervention was necessary if public health was to be protected (MacNeil, 1971).

## A GREATER ROLE FOR LOCAL GOVERNMENT: PROSPECTS AND PROBLEMS

The popularity (and basic necessity) of existing national programs for income security, health and social services are undeniable. Few would argue that they be dismantled and be passed to local or even provincial governments. While such programs are necessary, it is generally recognized that they are insufficient to achieve the desired improvement of health and social well-being for Canadians. For instance, there is little doubt that Medicare has succeeded in assuring more equitable access to vital hospital and physician services. Despite this advance, there are notable and troubling disparities in health care between the poor and the well-off, disparities which may worsen in the near future (Manga, 1986).

This paradox cannot be resolved by doing away with national programs, though. What is required is a different mix of services and programs. Without elaborating, an important part of the answer may lie in delivering a wider range of community-based health and social services. Part of this response is a greater role for local governments in the provision of the desired health and social services.

Advocates for a greater role point to Sweden, West Germany, other Western European countries and, in some respects, the United Kingdom, where local authorities have a considerable role in providing a wider range of what economists call "merit goods". These include education, housing, health, hospitals, as well as facilities and programs for the old, homeless, deaf, blind, disabled, mentally handicapped and needy women and children. Subsidizing rents for low-income families is also common in these countries. As well, means-tested income safety nets are also a local responsibility in some Western European countries.

We cannot present here all of the proposals for a greater role for local government in the health and social services fields. However, we wish to note one of the more radical proposals made by Dr. David Owen, a former minister of health in the U.K., who called for a genuine localist approach to the National Health Service organization. He urged adoption of a separately-elected health authority financed by local income taxes (Owen, 1979). However, he acknowledged that "the localist approach will still necessitate central government involvement in inspecting and upholding minimum standards... for planning national, regional and sub-regional facilities, and for avoiding wasteful self-sufficiency and duplication" (Owen, 1979, p. 1589). He was critical of the single hospital service established under the National Health Service in the late 1940s.

According to Rudolf Klein, one of the more astute analysts of the NHS, "the issue of the appropriate balance between centre and periphery continues to be a major political issue in the 1980s" (Klein, 1983, p. 18).

Critics of a greater role for local governments in Canada, however, point out that, in countries like Sweden, municipalities have historically been responsible for health and social services. They have also retained tremendous taxation powers to fund these services (Wilson, 1979). Another observation is that Sweden is fairly small and does not possess the degree of regional disparity found in Canada. Giving Canadian municipalities similar powers could create many problems because they lack the financial and taxation powers and the long experience of Swedish municipalities. As well, in Sweden, the municipalities are relatively large and few, in contrast to the thousands of small local governments in Canada.

In Sweden, local governments' capacity to expand services in response to changing need is well-established. Those who advise against increased local government involvement in health and social services in Canada point to the failure of local governments in the past and to their unknown future capacity to provide for changing needs and demands. Critics also fear that a greater local government role would increase regional and inter-provincial disparities; threaten income redistribution measures now in place; and weaken universality of health, income security and social services. They have some empirical support for these criticisms. There appears to be a strong correlation between high welfare state expenditures and strong central government authority over local or regional units. There is also a correlation between greater central government responsibility and greater emphasis on equality. Critics also point to the plight of the poor in the U.S., where local governments are experiencing tremendous difficulty in providing services basic to social and economic well-being.

In the following section, we provide the general arguments for and against local government provision of health and social services. We then suggest a reasonable direction for change in Canada.

## ARGUMENTS FOR AND AGAINST A GREATER ROLE FOR LOCAL GOVERNMENTS

An advantage commonly claimed for local government provision of services is that local governments are more likely to provide a quantity and quality of service consistent with the preferences and needs of local residents. Provincial and federal government provision is liable to result in uniform provision of services for reasons of administrative convenience. Higher levels of government have neither the capacity nor the inclination to ascertain variations in preferences from area to area. Local politicians and bureaucracies, it is claimed, are more likely to understand the local electorate's wishes than provincial and federal decision-makers.

It is also argued that decentralized provision may allow more democratic control of public officials and that joint responsibility for services would compel the various levels of government to cooperate. It is further argued that, if one level of government paid too little attention to the wishes of some groups, then those groups could exert pressure on other levels of government. In other words, multi-tier provision gives consumer groups more opportunity to voice their complaints and preferences.

Local responsibility for the provision of services may also result in greater efficiency in allocating resources because local electors would be more aware of the benefits and costs of services. Further, decentralization may lead to more experimentation and innovation in the production and delivery of services. It is often argued that local governments are in a better position than higher level governments to use different mixes of services to improve social well-being (Weale, 1978, p. 111). For example, local governments may choose to provide special housing programs and health and social services to the elderly and the handicapped as a substitute for the domiciliary care preferred by higher level governments, because the former is cheaper and provides a higher quality of living.

Advocates of a greater role for local governments are aware of the criticism that such devolution could result in unacceptable variations in service standards among regions. They raise two counter arguments: the first is that some variations in service are desirable and that the emphasis on egalitarianism is not always warranted; the second is that the central government could always specify service standards if the threat of differences in services is unacceptable. The chance of disparate levels of service is insufficient cause to take direct control of those services.

Several disadvantages must be considered before making major policy changes. Decentralization may have the following shortcomings.

First is the possibility of what public finance economists call "tax exporting", whereby some of the burden of local taxes is shifted to non-residents. Second, a fruitless and costly exercise in tax competition may arise as each local government tries to attract or retain industry through tax concessions or subsidies. Assuming some of the service costs were covered through grants from higher levels of governments, the taxes levied by local governments would understate the costs of services. Local politicians and bureaucrats would provide excessive services to maximize their own political and economic objectives rather than those of their constituents.

This scenario explains, in part, Proposition 13 in California in 1978 and Proposition 22 in Massachusetts in 1980. Brazer (1981) has argued that middle-class voters in both states believed they had paid too much taxes to support education, welfare and health that benefitted mainly minority groups. They also wanted to limit the burden of property taxes.

Local governments may be less efficient service providers, especially if their authorities lack experience in expenditure control and project management. Inefficiencies would be exacerbated if local authorities were too small to exploit economies of scale in the provision of services. Another argument against local government provision, and one pertinent to health and social services, is that local governments are likely to ignore any external benefits to non-residents and thus provide fewer services than are actually required. Local government boundaries were not drawn with health services in mind. Further, multi-tier provision of services entails higher administrative costs and more accountability and control problems. Local governments are subject to great risk to their economic base from fluctuations in economic activity and industrial relocation or restructuring resulting from international technological or competitive change (Kennedy, 1984). Hence, local governments cannot assure stable continuous provision of services as well as provincial or federal governments.

Finally, local government provision of health and social services may result in markedly different levels and standards of services. While minimum standards can be specified by the provincial or federal governments, determining these standards would be controversial and complicated, as would their monitoring and enforcement. Opponents of the decentralization option argue that it is incompatible with maintaining equity in the distribution of services -- the dominant objective of many health and social policies. Thus Klein refers "to the original dilemma of the NHS: the trade-off between seeking to achieve national standards (which implies centralization) and local autonomy" (Klein, 1983, p. 186).

There are also several political issues to be assessed in specific proposals. We noted earlier Dr. Owen's advocacy of a locally-elected health

authority. What are the relative merits of all-purpose elected authorities over specially-elected health authorities? Would one wish to apply the same principle to education? "The experience of New Zealand is not encouraging; local health authorities were directly elected and apathy was the norm" (Klein, 1983, p. 188).

Also, local authority is not necessarily a successful way to raise the voice of the consumer against the voice of the expert. "If it is the professionals who largely shape consumer expectations and perceptions of what is possible and desirable, then the paradox of local democracy may be to give more power to the local producers -- emancipated from the paternalistic rationalizers who, in the context of the national health care policy, provide a source of counter-expertise" (Klein, 1983, p. 188).

These arguments, both for and against, apply with greater or lesser force, depending on the specific health or social services under consideration. A single conclusion is not warranted and, in any case, would depend on the weight given to the many objectives in the arguments presented. It should also be apparent that the case for or against a greater role for local government in the provision of health and social services may indeed vary from one country or province to another.

In the Canadian situation, however, there are two major practical constraints to a greater role for local governments in the provision of health and social services. The first is constitutional: it is unlikely that local governments would be given true autonomy in these areas of social concern. All they can expect is some discretionary power to alter the quantity, quality or range of services first sanctioned by the provincial government. Second, given local governments' existing taxation powers and sources of revenue, they simply do not have the fiscal capacity to assume a radically greater role in these services. Municipal associations in a number of provinces have argued that municipal governments' taxing authority should be commensurate with their responsibilities in meeting social needs. That is, additional tax bases should be made available to them or, at the very least, the province should consider revenue-sharing with the municipal sector.

We will discuss the possible solutions to the problem of local government revenue and conclude that this problem alone vitiates a greater role for local government in the provision of health and social services. If local governments cannot fund these services, they cannot reasonably expect to determine their fundamental policies. The implications of the financial constraints plaguing local governments should not be minimized. Even with "greater expectations and demands, and the needs produced by urbanization for a greater range and higher levels of municipal services, many municipalities do not take full advantage of the possibilities. The directness, immediacy, and visibility of property taxation and high dependence on it sometimes even leads municipalities to ask that the provincial or federal government assume at least partial responsibility for service functions that municipalities can otherwise legally perform.

Although sometimes with reluctance, provincial governments have tended to agree to such requests, resulting in an erosion of municipal functional responsibilities" (Higgins, 1977, p. 55).

However, government's role has four dimensions, of which financing is just one. It is quite possible to enhance the role of local governments in administration, planning and delivery of health and social services even if

**Table 2: Local Government Fiscal Imbalance**

in thousands of dollars

| | 1980 | 1981 | 1982 p | 1983 p | 1984 p |
|---|---|---|---|---|---|
| Total Gross Revenue (All Provinces) | 27,266,258 | 31,399,512 | 33,832,544 | 35,749,910 | 37,938,027 |
| Total Gross Expenditures (All Provinces) | 28,071,381 | 32,027,718 | 35,888,969 | 37,805,397 | 39,079,435 |
| % By Which Expenditures Exceed Revenues | +2.95% | +2.0% | +6.0% | +5.7% | +3.0% |

p - preliminary statistics

Based on Statistics Canada figures (1985)

they do not assume a greater role in th financing. Depending on how the fiscal difficulties of local governments are resolved, they could undertake health and social services initiatives quite independently of provincial social policy. Indeed, our review offered several illustrations of such independent action.

**The Revenue Constraint**

Virtually every analysis of local government finances has confirmed the existence of an endemic "fiscal gap". The growing demand for local services equals or exceeds the growth in income, whereas the growth in local government revenue falls considerably short of the growth in expenditure or income. The root of this problem is the heavy reliance on property taxes, which do not rise with the growth in income. The "fiscal gap" is so much part of conventional wisdom that solutions to this

problem are almost always to transfer funds from provincial to local governments or, more radically, to give municipalities greater access to new tax sources. Insufficient attention is paid to filling the gap from existing local revenue sources. However, a number of studies have pointed out that local governments have not adequately exploited these sources (Bird, 1983; Young, 1977). There is scope for raising revenues from new charges or for revising existing charges for a variety of local government services (Bird, 1976). It has been pointed out as well that "the low apparent elasticity of the property tax may be largely the result of assessment practices and the unpopularity of the tax... it has been estimated that, over long periods (e.g. 1937-61), market property values in Ontario grew faster than personal income (although assessed values grew more slowly). Thus a property tax on the market values might actually have produced faster growing revenues than an income tax" (Young, 1977, p. 155).

Another potential source of local government revenue is increased urban land value. While local governments can and should be encouraged to raise additional revenue from local sources, provincial government transfers are likely to be inescapable and warranted, unless truly radical changes occur in the Canadian taxation systems, such as allowing municipal governments access to income, corporate and sales taxes. Such changes are both impractical and sometimes undesirable (Auld, 1979). There are few prospects for transformation of our tax and revenue structure in the near future and perhaps even in the long term.

The fiscal gap in Ontario and some other provinces has generally been filled by conditional grants from the provincial government although, recently, a number of provinces have resorted to more unconditional grants (Bird and Slack, 1983; Richmond, 1981). Local governments wish, of course, for greater discretion over their own spending and are therefore critical of the increasing reliance on conditional grants. For a long time, they have urged the provinces to adopt a system of unconditional or block transfer of funds.

There is a voluminous literature on the rationale for, and effects of, various types of grants or transfers from one level of government to another (King, 1984; Auld, 1976; Bird, 1976; Slack, 1981). Indeed, the terms used to describe types of grants are perplexing and sometimes confusing. Grants may be "specific" (sometimes called conditional) or "general" (sometimes called unconditional or even "block") depending on whether they are earmarked for particular expenditures (housing, roads, etc.) determined by the grantor. (i.e. Under a general grant, the local governments may choose to spend the transfers for whatever purposes they wish or even refuse to spend the transferred funds). General grants may be lump-sum or tied to the revenue raised by the recipient government. Specific grants too may be lump-sum or matching (cost-shared is another expression). Matching specific grants may be further subdivided into closed-ended or open-ended. In virtually every province, there is at least one example of each of the six forms of grants described above. There are legitimate reasons for having these different types of grants (King, 1984).

Table 3: Percentage Distribution of Sources of Revenue To Local Governments (All Provinces)

| SOURCES OF REVENUES | % IN 1980 | % IN 1981 | % IN 1982 | % IN 1983 | % IN 1984 |
|---|---|---|---|---|---|
| Property And Related Taxes | 35.5 | 35.5 | 36.79 | 37.65 | 37.83 |
| Privileges, Licences And Permits | 0.61 | 0.60 | 0.57 | 0.58 | 0.58 |
| Sale Of Goods And Services | 9.5 | 9.9 | 9.37 | 9.57 | 9.52 |
| Return On Investments | 2.7 | 2.8 | 2.4 | 2.1 | 2.0 |
| Other Own Source Revenues | 3.1 | 2.8 | 2.1 | 2.1 | 2.0 |
| Unconditional Transfers | 6.8 | 6.3 | 5.9 | 5.9 | 5.8 |
| Conditional Transfers | 41.54 | 41.48 | 42.7 | 42.0 | 42.0 |

*SOURCE: Based on figures in Local Government Finance, Statistics Canada: 1985.

Externalities in costs or benefits between municipalities are reasons often cited for conditional grants. This is not to suggest that all, or even most, of the existing conditional grants are justifiable or properly designed.

Most provinces have revenue-sharing schemes under which funds are transferred unconditionally to local governments. The amount transferred may simply be a fixed proportion of provincial revenues. In Saskatchewan, the amount transferred grows automatically with the provincial economy (Kwon, 1979). The distribution of funds among municipalities again varies from province to province. In Saskatchewan, municipalities receive

provincial unconditional grants on the basis of their expenditure needs and their revenue capacity. The most pertinent question is: if it is decided that the municipal role in the provision of health and social services should be enhanced, what type of grant should the provincial government favour to make this possible? The very question suggests some form of conditional grant. Because the services inherently redistribute funds and involve consumption factors, there is a good case for provinces to prefer conditional grants.

The municipal role in the financing of health and social services is limited and is likely to remain so. Provincial governments may be willing to permit a greater role for municipalities mainly through some form of conditional grants. Such grants also maintain the link between taxation and expenditure which, it is suggested, is essential for a truly responsible and accountable government. It seems to us that the provinces will and must continue to set the basic policy standards, and to be the primary funders of health and social services. It is the provincial governments that are responsible for assuring that the accessibility and quality of programs are not affected by regional economic disparities and intermunicipal differences in administrative capabilities and competence.

From the municipal point of view, an acceptable solution may be to fund health and social services at the provincial level but increase municipal responsibility for planning, administering or delivery. It would, however, make municipalities accountable to the province as well as to local residents. This situation would undercut one of the main arguments for increasing the local government role: as a democratically-elected body, local governments are responsible to the local taxpayers. Their role in health and social services would become similar to other government-sponsored agencies and susceptible to political and bureaucratic influence from the provinces. In addition, there is an inherent danger that lack of fiscal control may put unwarranted visibility, power or blame on municipal governments. These potential difficulties may be minimized, but are never likely to be absent, if there is cooperation between municipalities and provinces and scope for autonomous local decision-making.

**Administration**

There is potential for the larger local governments to increase their administrative role in the provision of health and social services, although differences in the structures and capacities of local governments must be considered before changing the system. Many of the larger municipalities have proven their administrative competence already. Increasing their administrative and planning responsibilities would allow provinces to decentralize health and social services, hence making programs more sensitive and responsive to local differences and preferences. Services could be evaluated more closely than they are at the provincial level, but provincial standards or guidelines would have to be maintained. Administrative decentralization is not as radical as other ideas that have

been contemplated. It would preserve the best of our present system, maintain provincial control and increase local accountability. Services which could best be administered at the municipal level include public health (already administered by many municipalities), children's services, local housing agencies and community services to the elderly.

As well as potential advantages there are, of course, potential disadvantages to be considered. Foremost is the fact that some municipal governments, especially the smaller ones, may lack the interest or the resources to expand their role. Further, there is a risk that administrative decentralization will complicate the system, decrease efficiency and strain the funds and authority municipal governments need to effectively administer services.

The greatest advantage would be the increased potential for citizen participation. People often feel that health and social policy is beyond their control because the decisions are made outside their community by unknown bureaucrats and technocrats. By contrast, municipal government is (or at least should be) very accessible to people. It is the only level of government in which a citizen can personally raise his or her concerns at an open council meeting. Officials live in the community which elects them and are accessible to the voters. Their term of office is only two or three years. There are usually no parties to support, so each official can vote as he or she wishes on any issue.

In some municipalities, there is evidence of an increasing municipal concern and involvement in health and social issues. For instance, on October 11, 1985, the Social Planning Council of Ottawa-Carleton urged voters to consider each candidate's position on social issues before municipal election day. Proposed cuts in the Regional Municipality of Ottawa-Carleton's social services budget for 1985 were overturned by council in response to citizen pressure. But this is not the general case. According to former Toronto mayor John Sewell (Globe and Mail, October, 1985, F6) there has been a serious decline in public attention to social issues in local politics.

We must also assess to what extent the provinces have devolved responsibility for social issues to local governments more to pass a politically unpopular buck than to empower the people and to produce the best solutions to social problems. Increased local control over health and social services could also jeopardize the principle of universality, inhibit access to services and put at risk our most vulnerable citizens. It would appear that provincial supervision of standards of care would be required no matter how services are provided.

**Planning**

While there is now little direct health and social service planning by municipal governments, this function could be expanded. Whether it is

advisable depends upon municipal capabilities, provincial functions and local planning bodies. Municipalities can and do make an important contribution to provincial planning (AMO Presidents Report, 1985). However, if provinces choose to devolve planning to the municipal level, it would be impossible to maintain uniform quality, costs and accessibility to services within one province. Realistically, few local governments have the resources, expertise, experience or desire to plan all the health and social services in their area. In any case, the provincial and federal governments are ultimately responsible for these very important services and could not allow municipalities to function independently of their policies.

Nevertheless, there is a continuous need for local planning and coordination. Even in communities where the existence of social planning and district health councils preclude forming a municipal planning body, services must still be allocated within the community. Municipalities are in a good position to choose the locations of services to best meet local needs. This function can be one aspect of their other planning functions and can be subject to the same scrutiny from residents as the rest of the official plan.

Evaluation is an important feature of any planning. Municipal governments are in a particularly good position to evaluate continuously health care and social services in the community, even if they do not directly deliver the services. One of the major criticisms of the Children's Aid Societies in Ontario is that many of them have no policy or mechanism to deal with citizens' complaints (Hurl, 1984). Municipal governments are a natural choice to deal with these circumstances since they are local and accessible and they already have procedures in place for receiving public complaints. As well, they have experience in dealing with other governments and agencies. They are also in a position to evaluate and monitor the use and effectiveness of services and to study future community needs. In fact, many regional and large municipal governments are experienced in needs assessment and evaluations of services such as day care and employment programs (Final Evaluation of the Human Resource Development Association, 1981; The Day Care Picture: Today, Tomorrow and the Way Forward, 1982).

### Delivery of Services

Municipalities now deliver a great number of social services and a few health services to the community. In general, these services are considered high quality (Report of the Joint Steering Committee on Integration, Monitoring and Evaluation: 1984) and, in many cases, less costly than similar services provided elsewhere. Municipally-delivered services are frequently praised for their flexibility and responsiveness to local and individual circumstances. We can assume that municipalities could deliver more services if their efforts were needed. In fact, there are more types of social and health services available than ever before. The

proliferation of self-help, voluntary and charitable organizations, combined with well-developed provincial systems, really leave few new services for which municipalities could seek new responsibility. Municipalities do, and should continue to, support voluntary and charitable organizations in the community.

Municipalities should consider becoming involved in the delivery of services which outgrow the means or scope of their founding organizations. When local services become essential to the community, and require public tax support, municipalities are the natural source of services and financial assistance and can help obtain provincial funding.

Services unlikely to be provided privately, or by other levels of governments, are also logical concerns for municipalities. For example, dental care for low-income families is provided by a municipal dental program in a very few communities. While these services are expensive and beyond the financial capacity of many local governments, nevertheless, more municipalities could provide them.

## CONCLUDING COMMENTS

Allowing local governments to become more deeply involved in the administration, planning and delivery of health and social services should enable them to better integrate these services. Many governments have seen integration of health and social services as a desirable goal, but few have had success and many have yet to seriously attempt integration (Hokenstad and Ritvo, 1982).

It is generally recognized that, while integration on a large scale is costly and produces an unwieldy system, integration for select groups (the poor, elderly, handicapped, mentally ill, etc.) is both desirable and easier to achieve (Clague et al., 1984). The higher incidence of illness and social need in these groups is undeniable. In coordinating provincial programs and policies, municipalities have acquired experience and expertise which should prove useful in further integrating health and social services.

There is great potential for even severely handicapped people to live in the community if they are assured adequate community support. At present, though, there is little or no coordination of health and social support services. Municipalities already have the expertise in social and special needs housing development, and they often administer home care, handicapped transit systems, education and other support services. To add health care services, probably purchased from local institutions, to the range of community services for special needs residents seems a logical step. Because the services would need to accommodate each resident's special needs, they would need to be offered at the local level.

A few local governments have proven their administrative competence, flexibility and responsiveness to local needs. In these cases, provincial government spending to support certain types of patients in chronic institutions could profitably be transferred to municipal agencies providing alternative care for such patients. While deinstitutionalization has not been successful in many instances (Gazette, October 19, 1985, A1 and A4), for example for the mentally ill, the causes of failure can be corrected by careful and collaborative planning and by long-term commitment to alternative forms of care.

One way for local governments to integrate health and social services is through public and professional education designed to increase awareness of local services available and how to use them. At present, health and

social services have proliferated and multiple jurisdictions are providing them, resulting in a system that "overservices but underserves" citizens or, at least, certain groups. Barriers to appropriate services exist for many needy persons and seem to bedevil human services agencies throughout the world (Levinson and Haynes, 1984). Physicians or hospitals are often the point of entry into the system even if the problem is a social one rather than a medical one. The effectiveness of treatment, therefore, depends entirely on the professionals' abilities to recognize and treat problems or to refer problems if they fall outside the professionals' field of expertise. Local information and referral services to help individuals find and use existing services are appearing in many communities. They are often sponsored and financed by local government as is the case in Edmonton.

Most people are able to access the services they need if they have the required information. Municipal governments can publish community service directories, as well as supporting local referral agencies, community advisory boards, displays and community awareness campaigns to inform the public of community services. With the enormous advances in information technology (much of which is now "user-friendly"), and the experience with existing information and referral systems, many municipalities should consider this inexpensive way of connecting people in need with services.

Housing for special needs groups is another area where municipalities could play a greater role. An important factor in current social housing problems is the sheer number of agencies, governments, housing authorities and private groups in the housing market. While this multiplicity has led to a diversity of approaches and facilities to meet widely different needs of communities across the country, it has prevented comprehensive local planning of social housing programs. While some municipalities already act as coordinators of community housing projects, there is tremendous potential to expand this role. There is also a need for more municipal commitment to developing community social housing programs, especially since federal-provincial housing strategies have failed to solve the current housing crisis. Nationally, the number of units financed in 1986 (22,500) is less even than the annual number in the 1970s (25,000), despite the greater need now. Even the city of Toronto, considered a leader in innovative housing, will probably build only 500 units in 1986 despite the estimated 20,000 Toronto households who need affordable housing (Globe and Mail, Dec. 31, 1985, A5).

There appears to be an unfortunate tendency for some municipal governments to ignore problems that are not their traditional responsibilities. John Sewell criticizes municipal governments for failing to respond to the problems of urban hunger, prostitution, housing and pornography in their cities (Globe and Mail, Dec. 31, 1985, A5). On the other hand, it is often argued that food banks and the like are not the solution to urban hunger; however, local governments have lent most of their support to these short-term measures.

However, a more charitable interpretation and understanding of the role of local government is also warranted. Food banks are a concrete manifestation of local government concern about the welfare of its poor residents. They are a first response to a crisis, and are rarely seen as a permanent, appropriate answer to poverty and hunger. The essential difficulty for local government is, of course, to decide to which of the current crises they should respond, since their resources fall far short of meeting the many needs they encounter. As well, it must be acknowledged that some "problems", such as prostitution, pornography and drug abuse, are complex and require the cooperation and collaboration of all three levels of government.

Some see the Ontario trend toward amalgamating public health services into regional government as a dangerous one. The concern is that the numerous other responsibilities of council may take precedence over public health issues and that these issues may not receive the interest they deserve.

It would be difficult and stupid to argue that all municipal governments should not or do not wish to be involved in health or social issues. In fact, the city of Thunder Bay has led other governments in developing an alcohol policy for its recreational facilities to deal with alcohol-related problems (Thomson et al., 1984). Many local governments have taken up the fitness challenge or have passed anti-smoking bylaws. Several cities have job-creation programs for population groups such as the disabled, ethnic minorities and women.

However, it must be acknowledged that many local councils have no urge to become more involved in health and social issues. Although local governments can and do lobby other levels of government for necessary policy changes, only the larger regional governments really have the power or the visibility to lobby effectively.

Also, as Weller has noted:

> Not only is city politics in Canada not about social issues, it is also not overly partisan. This means that major social issues do not get reflected at the local level because of the clash of ideologies that might well occur if things were overly partisan. Moreover, it means that the local level has not become a mechanism for expressing views on the national government and its policies as has become the case in, for example, the United Kingdom. Canada is very nearly unique in not having national or provincial political parties vie for power at the local level. In most other western nations they do so vigorously. (Weller, 1985)

Governments at all levels are vulnerable to criticism and pressure from a variety of vested interest groups. The desire to create local programs must be balanced against the danger of creating programs which serve local politicians, professionals and interest groups instead of those

they are supposed to serve. Lack of local government control over economic growth, stability and employment is a considerable risk to a continuous and stable role in the provision of health and social services. Our discussion about the difficulties and risks of a much greater role for local governments leads us to advise against giving them the fiscal and policy-making powers to tackle the many complex issues facing Canadian society. However, it should be noted that there is a reasonable case for involving local government more in the administration, planning and the delivery of health and social services.

Finally, it is important to recognize that it is difficult to envision a tidy, well-defined and universal role for local governments in these areas of social policy because of the wide disparities in size, resources and political interests of local governments in Canada. Thus, pragmatism must guide the various provinces in the directions they take to respond to the questions we have posed.

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**DE PLUS, VOUS RECEVEZ :**

- **Perception**, notre revue bimestrielle de développement social;
- trois bulletins trimestriels nationaux
  **Perspectives**, qui examine les questions, tendances et programmes sociaux au Canada;
  **Initiative**, qui s'adresse aux réseaux d'entraide;
  **Vis-à-vis,** qui fait le point sur l'actualité en matière de violence familiale;
- des tarifs préférentiels lors de votre participation aux conférences et aux ateliers du Conseil;
- des renseignements sur les nouvelles publications;
- le rapport annuel du Conseil;
- le droit de vote à l'assemblée annuelle;
- 20% de réduction sur tous les livres et les rapports.

| **Catégories et frais d'adhésion** | |
|---|---|
| **Particuliers :** | |
| • étudiant | 10$ |
| • membre | 50$ |
| • membre bienfaiteur | 75$ |
| **Organismes :** | |
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| • moins de 100 000$ | 75$ |
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| **Municipalités :** | |
| • par millier d'habitants (frais minimum 100$) | 2,50$ |

Pour devenir membre, veuillez envoyer votre nom, celui de votre organisme (le cas échéant), votre adresse complète, la catégorie d'adhésion et votre chèque à l'adresse suivante : CCDS, Services aux membres, 55, avenue Parkdale, Ottawa (Ontario) K1Y 4G1. Téléphone : (613) 728-1865.

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